Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON COMMUNITY HOSPITAL
PO BOX 11586
HOUSTON TX 77293

Respondent Name

FARMINGTON CASUALTY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-05-4599-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No Respond to my Request for Reconsideration HCH is Requesting we be reimbursed at usual & customary. Claim should be paid at Stop-Loss."

Amount in Dispute: $45630.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

Response Submitted by: None

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 30, 2004	Outpatient Surgery	$45630.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on February 25, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on March 4, 2005 to

send additional documentation relevant to the fee dispute as set forth in the rule.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - D-These services have already been considered for reimbursement.
   - M-Reimbursed per the insurance carrier/s fair and reasonable allowance.

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. 28 Texas Administrative Code §133.307(g)(3)(C)(iv), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, requires that the request shall include a position statement of the disputed issue(s) that shall include "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(C)(iv).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's position statement / rationale for increased reimbursement from the *Table of Disputed Services* asserts that "No Respond to my Request for Reconsideration HCH is Requesting we be reimbursed at usual & customary. Claim should be paid at Stop-Loss."
   - The requestor asks for reimbursement under the stop loss provision of the Division's *Acute Care Inpatient Hospital Fee Guideline* found in Division rule at 28 Texas Administrative Code §134.401(c)(6). The requestor asserts in the position statement that "Claim should be paid at Stop-Loss." 28 Texas Administrative Code §134.401(b)(2)(A) states "General Information. (A) All hospitals shall bill their usual and customary charges. The basic reimbursement for acute care inpatient services rendered shall be the lesser of (iii) reimbursement as set out in subsection (c) of this section for that admission." Because this was an outpatient hospitalization this admission is exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1
   - The requestor did not discuss or explain how it determined that 75% of the amount billed would yield a fair and reasonable reimbursement.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.

- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		1/5/2012
Signature	Medical Fee Dispute Resolution Officer	Date
		1/5/2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.